MANZON P.T.

MOBILE PHYSICAL THERAPY

Consent to Treatment:
I consent to and authorize Manzon P.T. to administer rehabilitation therapy treatment which includes cardiovascular exercise, weight training, manual therapy and stretching. I have been informed and understand that physical activity and exercise presents potential risks including, but not limited to, musculoskeletal injury, injury to the spine, high blood pressure or other abnormal blood pressure responses, and in rare instances, heart attack and death. Every effort will be made by my physical therapist to minimize these risks by monitoring vital signs.
I know it is up to me to inform my provider of rehabilitation therapy about any health problems or allergies I have, as well as medications I am taking.

Participation:
I am aware that I may discontinue participation in a physical therapy program at any time if I see fit to do so. Should I have any questions regarding the policies and procedures of my program, I will discuss these issues with my therapist immediately.
In addition to the above statements, I also agree to assume all risk of injury and property loss / damage arising out of my participation in the exercise program. I will not hold my therapist responsible or liable for any injury, including death, that is sustained while exercising, or for damage to or loss of property, which may occur during this program.

Privacy:
Manzon P.T. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties
and privacy practices with respect to your protected health information. You have the right to request restrictions on certain uses and disclosures of your health information. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. You have the right to inspect and copy your health information.

Authorization to Release / Obtain Information:
I hereby authorize the release of my patient health care information for the purposes of treatment or payment , to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Manzon P.T. to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. These correspondence can be made via mailings, telephone

and / or facsimile.

Insurance Eligibility:
Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance Benefits.

Financial Responsibility:
Payment is due at the time of the treatment. I understand that Manzon P.T. is an out-of-network provider for all private health insurance companies and a non-participating provider for Medicare. I understand that my private health insurance policy must have out-of-network benefits for reimbursement. I acknowledge that I must fulfill my annual out of network deductible. I agree to pay Manzon P.T. all amounts that are due for services rendered which are not otherwise paid for by the insurance plan on my behalf. I understand that insurance plan reimbursement does not guarantee full payment of treatment. It is recommended that you call your insurance carrier to verify insurance benefits.

Assignment & Release of Benefits:
I hereby appoint Manzon P.T. as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third party claims payment source, including my health insurer, Medicare or other governmental program while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment plan with the insurance carriers, physicians and other related health care professionals. I authorize the use of this signature on all insurance submissions.
As the assignor of the foregoing payment amounts, I direct that such payment be sent to Manzon P.T. and in the case that payment is made by my plan to me, I agree to remit such payment in full to Manzon P.T. no later than 10 days after my receipt.
Regarding Medicare, Manzon P.T. is a non-participating provider and does not accept assignments. I understand that I will receive reimbursement checks directly from Medicare in this case. I understand that reimbursement from Medicare will not cover the full cost of treatment.

Cancellation Policy:
I acknowledge that there is a strict 24 hour cancellation policy. I will cancel within 24 hours or accept the responsibility for paying a cancellation fee of $200.

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Patient Signature (Parent / Guardian) Printed Name Date